Shaping Age-Based Public Policy for Rural Areas

Discreet and profound changes in rural America are changing the face of small remote communities at a incremental but steady pace. Among these trends are the shift from agriculture and farming as the foundation of rural economics to manufacturing and service industry. Whitener (2005) notes that less than ten percent of rural people live on a farm and only 14 percent of the rural work forces are employed in farming.

Demographic patterns are also shifting with a noticeable rise in ethnic minorities among rural populations. Emigration patterns into rural areas are partly stimulated by economic opportunity, but rural minorities often live in places where poverty is high, opportunity is low, and future expectations are limited (DHHS, 2000).

Another trend impacting rural areas is the use of innovative technological techniques such as networking partnerships among health care providers and telemedicine. These initiatives are inspired by the need to reach heretofore unserved clients, and to leverage scarce resources. Another factor motivating these changes is the need to develop a consistent, sustainable service provider network in rural areas (Mueller, McBride, 2003).

The key to sustaining the change process in rural areas, however, is economic development. Economic development is a process of institution-building whereby semi-skilled subsistence employment is replaced by technologically-oriented jobs which pay surplus income. Investment capacity is enlarged so that developing communities can improve and build infrastructure—roads, medical facilities, schools, and adequate housing. Political decision-making is more sophisticated so that public authorities can make successful claims on financial support from central government. Values shift and place a premium on merit and achievement, and the sociopolitical distribution of resources smoothes out the relative disadvantage historically felt by under-developed areas (Brown, 1997).

Motivating the development process in rural areas is critical since weak economies spawn weak service delivery infrastructure which results in an inability to deliver services needed by people. This cycle of incapacity perpetuates itself as service delivery conditions continue to deteriorate. On the human side, there is a deficit of trained human service providers such as case managers, in-home workers, and professionalized human services administrators and managers. On the physical side, fragmented transportation systems cannot reach remote people, inferior roads and bridges make passage difficult. Lack of attractive positions for health care and medical staff coupled with low reimbursement rates to hospitals and clinics compound the problem. Ironically, where people are poorer, less healthy, and need is greatest, the ability to respond is weakest because people are poorer and less healthy.

However, as economic capacity is enhanced by the development process, so is human and physical infrastructure improved to reify the level of health and human services delivery to a standard which meets client needs, at least most of the time.

Such a sea change in rural economic development would require a dedicated commitment on the federal level giving fiscal and political authority to the states which, in turn, can inspire development on the local level.

Market forces, precipitated by documented need, can also be a factor in the development process in rural areas, particularly around health care delivery. However, local involvement needs to be nurtured and focused, as does local service capacity which cannot be fully addressed by markets. State support and technical assistance to local areas remains indispensable.

RESPONSE OF THE NETWORK

The penetration of elements to the aging network in rural areas has received mixed reviews (Krout, 1994). In particular, Area Agencies on Aging (AAA) have broad mandates under the Older Americans Act to proactively carry out a wide range of functions related to advocacy, planning, coordination, linkage-building, and community development and organizations and the like. These ranges of obligations are difficult to integrate into a clear focus, and AAA historically confronts these mandates often without corresponding authority, and adequate funding. Yet, AAA remains out on the frontier of local communities, with links to senior centers and other providers and especially to the state through state Units on Aging (SUA). This organizational network has great potential to effect change in local areas and has a long history of service delivery to older people. Much will depend on the quality and vision of local AAA directors and on the state level.

In a strategic sense, AAA and local providers need to construct and extend ongoing coalitions with health care providers on the community level. Since the OAA is a program of social support services, rather than health care, outreach to rural health clinics, physicians, hospital discharge systems, and long-term care case management organizations are key targets of coordination for the aging network (Brown, Goins, and Briggs, 2000). Substantial experience over the last decade in coordinating health and medical service in the Medicaid program has given the network experience in working with these entities.

Recommendation

The aging network, inspired by leadership from the Administration on Aging should pro actively outreach and work in support of those groups, organizations and individuals working in economic development settings in rural areas. A civic engagement and advocacy strategy needs to be developed by the network to integrate aging and economic development policy in rural America.

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